		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021436

Facility Name: Lewis Memorial Christian Village

Address: 3400 West Washington (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: 217-787-9600 **Fax #** 217-787-9601

IDPA ID Number: 51-0173104001

Date of Initial License for Current Owners: 9/77

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2000 to June 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP
600 East Adams - Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	79	28,835	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,445	13,969		26,414	8
9	SNF/PED					9
10	ICF	10,488	16,248		26,736	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,933	30,217		53,150	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.95%

D. How many bed-hold days during this year were paid by Public Aid?
125 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/19/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	248,493	29,651	18,525	296,669		296,669		296,669			1
2	Food Purchase		275,142		275,142		275,142	(1,779)	273,363			2
3	Housekeeping	147,106	18,906	6,221	172,233		172,233		172,233			3
4	Laundry	70,075	14,889	2,963	87,927		87,927		87,927			4
5	Heat and Other Utilities			164,241	164,241		164,241	725	164,966			5
6	Maintenance	93,625	11,851	78,526	184,002		184,002	10,635	194,637			6
7	Other (specify):*											7
8	**TOTAL General Services**	559,299	350,439	270,476	1,180,214		1,180,214	9,581	1,189,795			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,002,205	101,191	90,839	2,194,235		2,194,235		2,194,235			10
10a	Therapy			7,515	7,515		7,515		7,515			10a
11	Activities	25,669		1,627	27,296		27,296		27,296			11
12	Social Services	97,158	7,171	12,353	116,682		116,682	(2,036)	114,646			12
13	Nurse Aide Training											13
14	Program Transportation		138		138		138		138			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,125,032	108,500	112,334	2,345,866		2,345,866	(2,036)	2,343,830			16
	C. General Administration											
17	Administrative	129,450	3,240	225,318	358,008		358,008	(177,006)	181,002			17
18	Directors Fees											18
19	Professional Services			8,714	8,714		8,714	15,844	24,558			19
20	Dues, Fees, Subscriptions & Promotions			22,427	22,427		22,427	(31)	22,396			20
21	Clerical & General Office Expenses	63,601	13,119	51,050	127,770		127,770	18,047	145,817			21
22	Employee Benefits & Payroll Taxes			419,356	419,356		419,356	10,904	430,260			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,527	7,527		7,527	4,444	11,971			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,751	27,751		27,751	1,865	29,616			26
27	Other (specify):*							7,095	7,095			27
28	**TOTAL General Administration**	193,051	16,359	762,143	971,553		971,553	(118,838)	852,715			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,877,382	475,298	1,144,953	4,497,633		4,497,633	(111,293)	4,386,340			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lewis Memorial Christian Village #0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			166,417	166,417		166,417	7,866	174,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,169	148,169		148,169	(126,449)	21,720			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,980	1,980		1,980		1,980			36
37	**TOTAL Ownership**			316,566	316,566		316,566	(118,583)	197,983			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			164	164		164		164			39
40	Barber and Beauty Shops	29,526	1,609	1,249	32,384		32,384		32,384			40
41	Coffee and Gift Shops	12,022		35,068	47,090		47,090		47,090			41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* **Apt & Congregate**			677,196	677,196		677,196		677,196			43
44	**TOTAL Special Cost Centers**	41,548	1,609	798,540	841,697		841,697		841,697			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,918,930	476,907	2,260,059	5,655,896		5,655,896	(229,876)	5,426,020			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,779)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,866	30		9
10	Interest and Other Investment Income	(86,110)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,400)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(40,339)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,223)	21		24
25	Fund Raising, Advertising and Promotional	(809)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,423)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,217)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(90,659)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (90,659)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (229,876)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine	$ (2,036)	12	1
2	Activity Revenue	(387)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,423)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,779)	0	0	0	0	0	0	0	0	0	0	(1,779)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	725	0	0	0	0	0	0	0	0	0	725	5
6	Maintenance	0	10,635	0	0	0	0	0	0	0	0	0	10,635	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,779)	11,360	0	0	0	0	0	0	0	0	0	9,581	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(2,036)	0	0	0	0	0	0	0	0	0	0	(2,036)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,036)	0	0	0	0	0	0	0	0	0	0	(2,036)	16
	C. General Administration													
17	Administrative	0	(177,006)	0	0	0	0	0	0	0	0	0	(177,006)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,844	0	0	0	0	0	0	0	0	0	15,844	19
20	Fees, Subscriptions & Promotions	(809)	778	0	0	0	0	0	0	0	0	0	(31)	20
21	Clerical & General Office Expenses	(16,010)	34,057	0	0	0	0	0	0	0	0	0	18,047	21
22	Employee Benefits & Payroll Taxes	0	10,904	0	0	0	0	0	0	0	0	0	10,904	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,444	0	0	0	0	0	0	0	0	0	4,444	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,865	0	0	0	0	0	0	0	0	0	1,865	26
27	Other (specify):*	0	7,095	0	0	0	0	0	0	0	0	0	7,095	27
28	**TOTAL General Administration**	(16,819)	(102,019)	0	0	0	0	0	0	0	0	0	(118,838)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,634)	(90,659)	0	0	0	0	0	0	0	0	0	(111,293)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lewis Memorial Christian Village **#** 0021436 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,866	0	0	0	0	0	0	0	0	0	0	7,866	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(126,449)	0	0	0	0	0	0	0	0	0	0	(126,449)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(118,583)	0	0	0	0	0	0	0	0	0	0	(118,583)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(139,217)	(90,659)	0	0	0	0	0	0	0	0	0	(229,876)	45

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$			$ 725	$ 725	1
2	V	6	Maintenance				10,635	10,635	2
3	V	17	Administrative	220,608			43,602	(177,006)	3
4	V	18	Directors						4
5	V	19	Professional Services				15,844	15,844	5
6	V	20	Fees, Subscriptions				778	778	6
7	V	21	Clerical				34,057	34,057	7
8	V	22	Employee Benefits	3,122			14,026	10,904	8
9	V	23	Inservice Training						9
10	V	24	Travel&Seminar				4,444	4,444	10
11	V	26	Insurance				1,865	1,865	11
12	V	27	Depreciation				7,095	7,095	12
13	V								13
14	Total			$ 223,730			$ 133,071	$ * (90,659)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Reilly Mortgage		x	Bldg & Equip	$16,828.19	05/01/76	$ 2,557,200	$ 1,951,132	09/01/18	0.0750	$ 148,169	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$16,828.19		$ 2,557,200	$ 1,951,132			$ 148,169	9
	B. Non-Facility Related*											
10	Tax Exempt Bonds		x	Building Congregate		11/15/96	980,000		11/15/00	0.0700	1,438	10
11	Revenue Bonds 1991-C		x	Redeem Debt	$5,580.94	07/01/91	658,000	479,353	07/01/11	0.0775	38,901	11
12	Athens Athletic Assoc		x	Apartments		07/01/78	123,500		07/01/03	0.0500		12
13												13
14	TOTAL Non-Facility Related				$5,580.94		$ 1,761,500	$ 479,353			$ 40,339	14
15	TOTALS (line 9+line14)						$ 4,318,700	$ 2,430,485			$ 188,508	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	This W/P N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lewis Memorial Christian Village COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0021436

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE (217) 732-9651 FAX #: (217) 732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	** See Attached List		$ 79,041.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,041.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments
Congregate Living
Home Office

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	Various	$ 308,762	1
2	Home Office			7,919	2
3	TOTALS	217,800		$ 316,681	3

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	$ 2,286,830	$ 56,166	40	$ 57,171	$ 1,005	$ 859,810	4
5				1978	100,542		40	2,514	2,514	57,822	5
6				1979	420,937		20			420,937	6
7											7
8	Home Office Allocation				56,509	1,846		1,846		24,534	8
	Improvement Type**										
9	Land Improvement			1977			20				9
10	Land Improvement			1978			20				10
11	Bldg Improvement			1979	306	6	38	8	2	132	11
12	Bldg Improvement			1979			38				12
13	Land Improvement			1979			20				13
14	Land Improvement			1979			20				14
15	Land Improvement			1980			20				15
16	Bldg Improvement			1981	4,662	155	30	155	0	3,075	16
17	Heating/Cooling Systems			1981	20,153	1,008	20	1,008	(0)	19,824	17
18	Exhaust Fan			1983	417		15			417	18
19	Land Improvement			1984			20				19
20	Door Assembly			1985	1,244	62	20	62	0	992	20
21	Land Improvement			1985			20				21
22	Crackfill Parking Lot			1986			15				22
23	Bldg Improvement			1986	573	29	20	29	(0)	440	23
24	Landscaping			1986			20				24
25	Pass-thru WD			1986	664	33	20	33	0	481	25
26	RD & Drainage			1986			20				26
27	Fire Hydrant			1987			20				27
28	Gravel Road			1987			10				28
29	Parking Lot			1987			20				29
30	Remodeling			1987	800	40	20	40		573	30
31	Rooftop Compressor			1988	3,408		10			3,408	31
32	Air System			1989	1,090	55	20	55	(1)	683	32
33	A/C Unit			1989	4,406		8			4,406	33
34	Remodeling			1989	6,193	310	20	310	(0)	3,823	34
35	Tile, Cover Base			1989	6,600		5			6,600	35
36	Wall Paper			1989	826		5			826	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Softner	1989	$ 3,475	$ 232	15	$ 232	$ (0)	$ 2,881	37
38	Cabinets	1990	100	20	15	7	(13)	97	38
39	Parking Lot Resurface	1991			8				39
40	Roof Top A/C Unit	1991	4,158	414	10	416	2	4,158	40
41	Command Moduole	1991	1,318		5			1,318	41
42	Wall Paper/Carpet	1991	14,848		5			14,848	42
43	Drapery Hardware	1991	1,124		5			1,124	43
44	Carpeting	1992	640		5			640	44
45	Curtain Track	1992	523		5			523	45
46	Curtain Track	1992	4,124		5			4,124	46
47	Receptacle	1992	575	58	10	58	(1)	541	47
48	Curtain Track	1992	565		5			565	48
49	Curtain Track	1992	1,229		5			1,229	49
50	Fire Alarm	1992	621	31	20	31	0	266	50
51	Door Control	1993	722	48	15	48	0	408	51
52	Nurse Station Remodel	1993	30,556	1,528	20	1,528	(0)	11,857	52
53	Wallcoverings	1993	751		5			751	53
54	Fire Alarm	1993	658	33	20	33	(0)	267	54
55	Land Improvements	1993			10				55
56	Wallcoverings	1994	3,747		5			3,747	56
57	A/C Compressors	1994	1,506	151	10	151	(0)	1,195	57
58	Exhaust Fans	1994	2,183	146	15	146	(0)	1,156	58
59	Roof Entire Building	1993	125,670	8,378	15	8,378		63,991	59
60	Downspout Repairs	1994	6,000	400	15	400		3,000	60
61	Ceiling Tile	1994	1,149	115	10	115	(0)	853	61
62	Wallpaper/Floor Covering	1994			5				62
63	Wallpaper/Floor Covering	1994	20,655		5			20,655	63
64	Wallpaper	1994			5				64
65	Lounge Remodel	1995	14,653	(189)	5	(189)		14,653	65
66	Volunteer Room Expansion	1995	8,435	843	10	844	1	4,392	66
67	Remodel Wing 100	1995	44,657	4,645	10	4,645		35,694	67
68	Remodel Shower Wing	1995	24,272	2,343	5	2,343		15,637	68
69	Wallcovering	1995	35,194		5			35,194	69
70	TOTAL (lines 4 thru 69)		$ 3,270,268	$ 78,906		$ 82,413	$ 3,507	$ 1,654,547	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,270,268	$ 78,906		$ 82,413	$ 3,507	$ 1,654,547	1
2	Enclosed Shelter	1995			10				2
3	Stainless Steel Floor Cooler	1996	1,873	248	5	248		1,873	3
4	Wanderguard Alzheimer	1996	10,455	1,046	10	1,046	(1)	5,327	4
5	Wallcovering	1996	3,910	652	5	3,910	3,258	3,910	5
6	Wallcovering	1996	22,106	4,421	5	4,421	0	21,737	6
7	Wallcovering	1997			5				7
8	Gas Meter & Lines	1997	7,378	1,476	5	1,476	(0)	6,396	8
9	Maglocks & Keypad	1997	7,194	719	10	719	0	3,116	9
10	Nurse Call System	1997	9,727	973	10	973	(0)	4,213	10
11	Resurface Parking Lot	1997			3				11
12	Wallcovering	1997	49,523	5,627	5	5,627		43,711	12
13	Exhaust Fan	1997	12,370	1,237	10	1,237		4,845	13
14	Upgro Energy Management System	1997	14,513	1,451	10	1,451	0	5,683	14
15	Upgro Antennae System	1997	2,400	480	5	480		1,840	15
16	Fire Alarm	1997	560	112	5	112		420	16
17	Hot Water Heater	1997	21,667	2,167	10	2,167	(0)	8,126	17
18	Wallcovering	1997	6,836	1,367	5	1,367	0	4,898	18
19	Fire Safety Gas Valve	1998	617	123	5	123	0	431	19
20	Locks	1998	782	156	5	156	0	533	20
21	Wiring for Network	1998	625	125	5	125		406	21
22	Landscaping Courtyard	1998			5				22
23	Resurface Parking Lot	1998			3				23
24	Outlets for Kronos	1998	664	133	5	133	(0)	366	24
25	Entrance Canopy	1998	3,667	733	5	733	0	1,894	25
26	Fire Alarm Control Panel	1998	28,154	2,815	10	2,815	0	7,272	26
27	Repl Fire Alarm Device	1999	4,800	480	10	480		1,160	27
28	Kitchen Hood	1999	6,910	691	10	691		1,612	28
29	Fire Alarm Devices	1999	4,600	460	10	460		1,073	29
30	Garage	1999			40				30
31	Replace 8 Shower Valves	2000	10,084	2,017	5	2,017	(0)	3,698	31
32	Panduit Raceway	2000	13,130	1,313	10	1,313		2,298	32
33	Kitchen Ceiling	2000	5,923	592	10	592	0	789	33
34	TOTAL (lines 1 thru 33)		$ 3,520,736	$ 110,520		$ 117,286	$ 6,766	$ 1,792,174	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,520,736	$ 110,520		$ 117,286	$ 6,766	$ 1,792,174	1
2	Kitchen Walls	2000	2,099	210	10	210	(0)	228	2
3	CARPET #207	2000	1,344	247	5	247		247	3
4	WATER HEATERS	2001	37,299	1,243	10	1,243		1,243	4
5	NATURAL GAS REGULATOR	2001	1,184	39	10	39		39	5
6	40 GALLON WATER HEATER	2001	506	4	10	4		4	6
7	Less Disposals in 2001		(26,981)	(2,421)		(2,421)		(11,960)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	total ties to 2000								32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,536,187	$ 109,842		$ 116,608	$ 6,766	$ 1,781,975	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 391,334	$ 41,552	$ 41,552	$	Various	$ 189,027	71
72	Current Year Purchases	48,710	3,206	3,206	(0)	Various	3,206	72
73	Fully Depreciated Assets	421,061					421,061	73
74	Home Office Allocation	49,324	5,091	5,091			40,105	74
75	TOTALS	$ 910,429	$ 49,849	$ 49,849	$ (0)		$ 653,399	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1989 Ford Bus	1989	$ 38,359	$	$	$	5	$ 38,359	76
77	Patient Transport	1993 Chevy Pick-Up	1998	13,290	4,430	4,430		5	11,444	77
78										78
79	Home Office Allocation			10,741	2,296	3,396	1,100		3,311	79
80	TOTALS			$ 62,390	$ 6,726	$ 7,826	$ 1,100		$ 53,114	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,825,687	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	166,417	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	174,283	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	7,866	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,488,488	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment, Carport & Equipment	$ 472,785	$ 15,116	$ 281,858	86
87	Duplex Bldg & Land Improvement	4,343,823	155,929	1,178,713	87
88	Duplex Equipment	135,257	6,496	100,728	88
89	Congregate Bldg & Land Improv.	4,057,258	100,175	936,428	89
90	Congregate Equipment	132,161	6,605	101,999	90
91	TOTALS	$ 9,141,284	$ 284,321	$ 2,599,726	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 15,478	92
93			93
94			94
95		$ 15,478	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs	This Workpaper is not applicable					#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,889,762	$	1
2	Cash-Patient Deposits	36,282		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,348)	367,052		3
4	Supply Inventory (priced at)	19,022		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,453		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,878		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,317,449	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	11,326,691		14
15	Leasehold Improvements, at Historical Cost	699,533		15
16	Equipment, at Historical Cost	1,198,733		16
17	Accumulated Depreciation (book methods)	(5,018,404)		17
18	Deferred Charges	16,438		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,302,534		21
22	Other Long-Term Assets (spe CIP	15,478		22
23	Other(specify): Contract Receivable			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,849,765	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,167,214	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,684	$	26
27	Officer's Accounts Payable	22		27
28	Accounts Payable-Patient Deposits	35,130		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,175		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,102		32
33	Accrued Interest Payable	12,195		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 397,309	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,951,132		40
41	Bonds Payable	479,353		41
42	Deferred Compensation	1,587,677		42
	Other Long-Term Liabilities(specify):			
43	End Net Assets	2,061,246		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,079,408	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,476,716	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,690,498	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,167,214	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,926,233	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,926,233	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	764,265	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 764,265	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,690,498	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,090,887	1
2	Discounts and Allowances for all Levels	(931,216)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,159,671	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,036	12
13	Barber and Beauty Care	35,946	13
14	Non-Patient Meals	1,779	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	383	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,143	23
	D. Non-Operating Revenue		
24	Contributions	278,071	24
25	Interest and Other Investment Income***	116,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 394,331	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential & Congregate	844,388	28
28a	Unrealized G/(L) on Sale of Equip & Investments	(18,372)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 826,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,420,161	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,180,214	31
32	Health Care	2,345,866	32
33	General Administration	971,553	33
	B. Capital Expense		
34	Ownership	316,566	34
	C. Ancillary Expense		
35	Special Cost Centers	709,744	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37	Wellness Center	47,090	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,655,896	40
41	**Income before Income Taxes (line 30 minus line 40)****	764,265	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 764,265	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,786	1,786	$ 46,351	$ 25.95	1
2	Assistant Director of Nursing	1,538	1,538	32,318	21.01	2
3	Registered Nurses	11,573	12,353	244,533	19.80	3
4	Licensed Practical Nurses	28,397	29,467	456,972	15.51	4
5	Nurse Aides & Orderlies	104,169	108,805	1,139,080	10.47	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director	2,855	3,017	38,483	12.76	9
10	Activity Assistants					10
11	Social Service Workers	10,007	10,601	84,324	7.95	11
12	Dietician		0			12
13	Food Service Supervisor	1,913	1,977	26,307	13.31	13
14	Head Cook		0			14
15	Cook Helpers/Assistants	25,039	25,873	222,186	8.59	15
16	Dishwashers		0			16
17	Maintenance Workers	7,507	7,829	93,625	11.96	17
18	Housekeepers	16,366	17,032	147,106	8.64	18
19	Laundry	7,480	7,778	70,075	9.01	19
20	Administrator	3,807	3,967	124,554	31.40	20
21	Assistant Administrator		0			21
22	Other Administrative	4,034	4,203	38,936	9.26	22
23	Office Manager	2,052	2,138	29,560	13.83	23
24	Clerical	3,691	3,691	30,929	8.38	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)	5,574	5,574	52,043	9.34	30
31	Medical Records		0			31
32	Other Health C: Wellness Center	1,136	1,136	12,022	10.58	32
33	Other(specify) Beauty Shop	2,224	2,346	29,526	12.59	33
34	TOTAL (lines 1 - 33)	241,148	251,111	$ 2,918,930 *	$ 11.62	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	164	$ 8,017	1.3	35
36	Medical Director	390	390	10a.3	36
37	Medical Records Consultant	0	900	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	0	3,593	10.3	39
40	Physical Therapy Consultant	107	6,405	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	720	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	149	8,689	12.3	45
46	Other(specify) Dental Consultant Fe	4	1,300	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	814	$ 30,014		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Florence	Administrator	0	$ 81,741
Mary Florence		0	1,233
Scott Hurley		0	46,476
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,450

B. Administrative - Other

Description	Amount
Management Fee	$ 220,608
Employee Bonus Allocation	4,710
TOTAL (agree to Schedule V, line 17, col. 3)	$ 225,318
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Booth, Little, Antoline	Legal	$ 162
Van Ostrand & Elvidge Kelley	Legal	6,804
Melotte Morse-Leonatti	Consultant	1,445
GRW Architechural	Consultant	60
Comp App Sol	Computer Consultant	244
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,714

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,304
Unemployment Compensation Insurance	17,352
FICA Taxes	230,996
Employee Health Insurance	97,800
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	8,904
Employee Physicals	6,778
Workers Comp Med Exp	812
Less Apt & Congregate	(23,590)
Home Office Allocation	10,904
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,260

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,229
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	14,389
HO Allocation	778
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,396

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached Detail	7,527
HO Allocation	4,444
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,971

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lewis Memorial Christian Village **#** 0021436 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $5849.25**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,908** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,779)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will mail when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.